

**RULES  
OF  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF INSURANCE ADMINISTRATION**

**CHAPTER 0620-5-1  
COVER KIDS RULES**

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**0620-5-1-.01 DEFINITIONS.**

- (1) Unless otherwise specifically defined in these rules, these terms will have the following meaning:
- (a) “Administrative Contractor” or “AC” is the entity responsible for determining eligibility of applicants to CoverKids. This may be a private contractor, government agency, or Departmental entity.
  - (b) “Budget Group” means for each applicant, the following family members living with the applicant: the applicant’s spouse, the applicant’s minor unmarried children, the siblings of children in the home when the applicant child and siblings do not have income of their own, and each of the applicant’s financially responsible adults as indicated by the family including natural, adoptive, and step-parents. Children with SSI or Families First are not included in a budget group.
  - (c) “Commissioner” is the executive officer in charge of the Tennessee Department of Finance and Administration.
  - (d) “Commissioner’s Designee” means a person or group of persons appointed by the Commissioner to perform a particular function under these rules.
  - (e) “CoverKids” is the program created by Tennessee Code Annotated Section 71-3-1101 et seq. and includes its authorized employees and agents as the context of the rules requires.
  - (f) “Days” means calendar days rather than business days.
  - (g) “Meaningful Access” is insurance coverage that includes a network of providers within a reasonable distance from the area in which the covered individual lives.
  - (h) “Parent” means a natural or appointed guardian of minor children as defined by Title 34, Part 1 of Tennessee Code Annotated subject to court orders entered or recognized by the courts of the state of Tennessee.
  - (i) “Plan Administrator” or “PA” is the entity responsible for providing health care services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.

(Rule 0620-5-1-.01, continued)

- (j) “PE Entity” is a CoverKids contractor which has been authorized by CoverKids to determine that a newborn baby or a pregnant woman is presumptively eligible for CoverKids according to the rules and procedures established by CoverKids.
- (k) “SSI” means Supplemental Security Income benefits provided by the Social Security Administration.

**Authority:** T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.

**0620-5-1-.02 ELIGIBILITY.**

- (1) Citizenship.
  - (a) Children and pregnant women applicants must be citizens of the United States or, persons designated as qualified aliens under 8 U.S.C. Sections 1641 and 1642 as applied to programs under Title XXI of the Social Security Act by federal law including 42 C.F.R. 457.320(b)(6).
  - (b) CoverKids will comply with applicable amendments to Federal laws and regulations concerning eligibility of non-citizens.
- (2) Residency.
  - (a) The applicant must be a resident of the state of Tennessee.
- (3) Social Security Number.
  - (a) All applicants must have a Social Security Number (SSN) or proof of application for a SSN. For newborns less than 4 months of age an application for an SSN must have been filed and a copy of the SSN application provided. SSN are not required for parents and children not applying for CoverKids coverage.
  - (b) Families with children under 4 months of age who were approved for CoverKids coverage without an SSN number must submit the SSN number to the AC within three (3) months of the first day of CoverKids coverage.
- (4) Age.
  - (a) Applicants must be either a child under 19 years of age or a pregnant woman. CoverKids coverage for children ends the last day of the month in which the child turns 19.
  - (b) A female that that become pregnant at 18 years of age with a delivery date that occurs after her 19<sup>th</sup> birthday, will be allowed to retain coverage so as not to create discontinuity of care for prenatal, delivery, and post-partum care. This coverage will continue until the end of the month in which the 60<sup>th</sup> postpartum day occurs. All services rendered would be related to post-pregnancy care.
  - (c) Information of the child’s age on the CoverKids application is sufficient verification of age. Any applicant for whom a date of birth is not provided will be denied CoverKids coverage.
- (5) Insurance Coverage.
  - (a) Factors in Determining Current Insurance Coverage.

(Rule 0620-5-1-.02, continued)

1. The applicant must not be currently covered under a comprehensive health insurance policy for either individual, group or employer-based insurance, or
  2. The must not have had comprehensive individual, group or employer-based health insurance in the past three months, including Medicare, with exception allowed for Non-Voluntary Loss of insurance. Applicants will not be eligible for coverage any earlier than the fourth month after the private coverage ends. Applications received within one month of the first eligible month will be processed for coverage.
  3. Specialty insurance coverage, such as dental-only or catastrophic-only coverage, is not considered comprehensive health insurance.
  4. Coverage through the State of Tennessee's Children's Special Services (CSS) program is not to be considered comprehensive health insurance for eligibility purposes.
  5. Information on the CoverKids application is sufficient verification of an applicant being uninsured. The State reserves the right to investigate the insurance status of applicants. The CoverKids application must be submitted with a copy of the front and back side of the insurance card for any applicants who are insured.
- (b) If the applicant is a pregnant woman with individual, group or employer based health insurance, she may be enrolled in CoverKids if her insurance does not cover prenatal/maternity care. The AC will use the information on the application, the copy of the insurance card and information obtained by contacting the insurance company to determine if prenatal/maternity care is covered by the private insurance.
- (c) If the AC receives information from the family that applicants with private health insurance do not have meaningful access to the health services provided under the plan, the AC can consider the applicants uninsured for eligibility determination purposes.
- (6) Assets.
- (a) No asset test is used.
- (7) Income.
- (a) To be eligible for CoverKids, children and pregnant women must have adjusted gross income above TennCare Medicaid levels but below 250% of the Federal Poverty Level. CoverKids may enroll persons above 250% of the Federal Poverty Level under the terms and conditions set forth in these rules. To be consistent with the calculations used for TennCare Medicaid, this program will interpret the rules consistent with the guidelines currently used by that program for determination of both budget groups and income calculation to the extent such guidelines are applicable to the CoverKids program. Further, these rules and applications thereof are subject to change in accordance with any mandatory regulations or directives issued from the federal level.
- (b) The CoverKids application will request income information for adults who are parents (biological, adopted or step) and for caretaker relatives who are caring for children when neither parent lives in the home or in the event a parent lives in the house but the parent's current circumstances or conditions necessitates that a caretaker relative is the responsible adult assuming care of that child. This will be deemed the case if the

(Rule 0620-5-1-.02, continued)

application lists the caretaker relative as the responsible adult or if the parent and caretaker relative are both listed as the responsible adults.

- (c) All family income of the budget group must be reported on the application. Self-declaration of income by the applicant is sufficient verification and must include the payee's name and the gross amount of monthly income. Although received by the responsible parent on behalf of the child, income such as child support and Social Security benefits is considered as income of the child.
- (d) The financial eligibility for CoverKids will be calculated as follows:
  - 1. Depending on family/household relationships, a family may be comprised of one or multiple budget groups.
  - 2. If a child receives income and is applying for coverage, then that child and his income must be counted in the budget group.
  - 3. If a pregnant female is under the age of 19 and lives in the household with her parents, the minor's budget group would consist of the pregnant minor and her parents.
  - 4. When the baby is born, the mother and the baby will comprise the budget group. The baby would be screened for CoverKids eligibility.
- (e) Whose Income to Count in The Budget Group. The available income of the following individuals is considered part of the budget group's countable income.
  - 1. Income of the Financial Responsible Adult(s).
  - 2. SSI, Families First income, and VA Pension income is not included in the income calculation.
  - 3. Child's Income Countable income belonging to the eligible child (under 19) who is included in the Budget Group is considered in its entirety exclusive of any disregarded amount(s).
  - 4. Income belonging to a child (individual under age 19) in his/her own right including income specially designated for him such as Social Security benefits or child support, is considered available solely to the child and is not deemed to any other individual unless the child is also a parent. If the child is a parent, the rule of financial responsibility applies.
  - 5. Income Belonging to a Caretaker Relative who is not a financially responsible adult is not considered to be part of the Budget Group's countable income unless the caretaker relative requests inclusion in the Budget Group and he/she is otherwise eligible. This may be advantageous if caretaker relative is pregnant. The caretaker relative who is an SSI or FF recipient does not have the Budget Group inclusion option.
- (f) Whose Income to be Counted in the Budget Group. Explore income available to all members of the household in which the applicant resides.
  - 1. Income belonging to any household members unrelated to the members of the Budget Group is unavailable to the group. A remarried caretaker relative who is pregnant or under age 19 who elects inclusion in the BG may have income deemed to him/her from his/her spouse. Further, a remarried responsible adult

(Rule 0620-5-1-.02, continued)

may have income deemed from his/her spouse if the spouse requests inclusion in the budget group as indicated as that spouse being named as the second responsible adult.

2. The income of any individual including a legal parent, living permanently outside the household is not available to the Budget Group.
3. Income belonging exclusively to the child excluded from the Budget Group, including those who exercise their exclusion option, is not available to members of the Budget group unless the child is a parent or spouse of a Budget Group member.
4. The income of a recipient of a VA pension based on need is not included in the Budget Group income unless the recipient's needs are included.

(g) Countable Income.

1. Income of any SSI or FF recipient, including a legal parent, are not considered available to members of the Budget Group.
2. Eligibility determination is done on a monthly basis; therefore, income must be converted to a monthly amount. The following formulas should be used:
  - (i) Hourly or piece Work. Multiply the hourly wage by the number of hours the individual worked or is expected to work in a week to determine the weekly earnings figure. Convert the weekly figure to a monthly figure; or
  - (ii) Determine the number of pieces an individual averages per day and determine the number of days per week. Multiply these two figures to determine a weekly figure. Convert the weekly figure to a monthly figure as described following.
  - (iii) Weekly Income – Multiply weekly income by 4.3 to determine monthly income.
  - (iv) Bi-Weekly Income – Multiply the amount received every two weeks by 2.15 to determine the monthly amount.
  - (v) Semi-Monthly Income – Add the two semi-monthly amounts together to determine the monthly amount.
  - (vi) Annual Income – Divide the full amount of annual income by 12 to determine the average monthly amount.

(h) Financial Factors - The AC will calculate each budget group's adjusted gross income for the month that eligibility will begin based on recent income information provided by the family on the CoverKids application. Adjusted gross income is the sum of all countable income for persons in the budget group minus all deductions. Therefore, these deductions are subject to change if DHS guidelines change. Further, these guidelines are subject to change in accordance with any mandatory federal regulations.

1. Income Deductions. The following should be deducted:
  - (i) A standard \$90 work expense deduction from countable earnings is allowed.

(Rule 0620-5-1-.02, continued)

- (ii) \$30 plus 1/3 of a fiscal group member's remaining earned income if the member received Families First cash assistance or Low Income Family medical coverage from the DHS in at least one of the four calendar months preceding the month of the eligibility budget.
  - (iii) Child care payments. For the purposes of CoverKids, a standard \$200 is deducted monthly, per child, for which the applicant claims a child care expense, regardless of the actual amount of the expense. (The Child Care section below provides details on determining who is eligible for this deduction.)
  - (iv) \$50 from the total child support received for each child.
  - (v) 65% of rental income for administrative purposes, or the actual rental expenses if the landlord claims a larger expense.
  - (vi) For self-employment, deduct the actual operating expenses claimed. Operating expenses are based on the family's statement for self-employed persons, including depreciation. (Net loss; federal, state, and local income taxes; personal business expenses, including entertainment and retirement funds, are NOT considered deductions.) Court-ordered child support paid by a fiscal group member for a child who does not live with the fiscal group. Arrearage payments are not deductible.
  - (vii) \$60 from guardianship/conservator fees paid.
2. Child Care (dependent care) may be deducted only if the following are met:
- (i) A child must be living with the family member, who is paying for the care,
  - (ii) Child must be that family member's child,
  - (iii) Child must be under age 15, or under age 18 and need care because of a mental or physical limitation,
  - (iv) Other parent is not available to provide the child care due to conflicting work, school or training schedules,
  - (v) If the family has any monetary obligation for child care for an eligible child, the full \$200 child care deduction is budgeted as an expense. If the full amount of the child care is paid by another entity (e.g., DHS), the child care deduction cannot be allowed. Example: The child has a child care expense of \$300 monthly. DHS pays \$150 of this care. Because the family has an obligation to pay the balance of the child care, the full \$200 deduction is allowed. If the entire \$300 is paid by DHS, no deduction would be allowed.
3. Add the total allowable child care deduction to get each family's total deduction for child care.
4. This total amount is used as the child care deduction for each child's budget.

(8) Non-factors.

- (a) The following must not be a factor in determining CoverKids eligibility:

(Rule 0620-5-1-.02, continued)

1. Disability status.
  2. Pre-existing condition (except pregnancy).
  3. Diagnosis (except pregnancy).
- (9) Excluded Children.
- (a) Individuals who are not eligible for CoverKids include children who:
    1. Are eligible for TennCare Medicaid.
    2. Are enrolled in TennCare Medicaid or TennCare Standard.
    3. Have been criminally adjudicated and are in a correctional facility, including a detention home or training school.
    4. Are admitted to an institution for mental disease.
    5. Are eligible for health insurance coverage on the basis of a family member's (self, parent, spouse, etc.) employment by a state or local governmental agency.
    6. Have had comprehensive individual, group or employer-based health insurance in the past three months and voluntarily discontinued the comprehensive insurance, regardless of the cost.
  - (b) When the AC is made aware that any CoverKids beneficiary meets one of the conditions above, the AC will contact the family to verify the information received (if not received from family) and if verified, will disenroll beneficiaries from CoverKids. The AC will send a termination letter to the families. Disenrollment and Review shall be conducted under the procedures set forth in rule 0620-5-1-.04 and 0620-5-1-.05 of these rules.
- (10) Updated Federal Poverty Levels.
- (a) Upon release by the federal government of a new calendar year's Federal Poverty Levels (usually in late winter), the AC will review all CoverKids denials that were previously conducted during the new calendar year to determine if applying countable family income to the new FPL thresholds would make any individuals eligible. For those found to be eligible using the new FPL, the AC will process the application for enrollment based on this new information.
- (11) Presumptive Eligibility.
- (a) Presumptive Eligibility for Pregnant Women (PE-PW)-CoverKids Healthy Babies Program allows a pregnant woman to have immediate CoverKids coverage that begins on the day of the visit to a PE Entity as long as a complete, signed CoverKids application is submitted and all PE requirements are met. The eligibility begins on date of signed application. To be eligible for PE-PW, the applicant must:
    1. Be a citizen or, as defined in federal law, an eligible immigrant.
    2. Live in a family with adjusted gross income, as reported to the PE Entity, which is above 185% FPL and at or below 250% FPL.
    3. Work with the PE Entity to submit a complete, signed CoverKids application.

(Rule 0620-5-1-.02, continued)

4. Not have had PE-PW within the last 18 months.
  5. Not be currently enrolled in TennCare or CoverKids.
  6. Not be currently enrolled in comprehensive health insurance coverage. (If a pregnant woman has health insurance that does not cover prenatal/delivery services, she will not be considered to have comprehensive health insurance coverage.)
  7. Not have been enrolled in comprehensive health insurance coverage that was voluntarily terminated at any time within the three months prior to the visit with the PE Entity. (If a pregnant woman had health insurance that did not cover prenatal/delivery services, she will not be considered to have had comprehensive health insurance coverage.)
  8. Not have access to state administered health insurance by means of a family member's employment with a state or local government agency.
- (b) Presumptive Eligibility for Newborns (PE-NB) allows a newborn to have immediate CoverKids coverage that begins on the day of the visit to a PE Entity as long as a complete, signed CoverKids application is submitted and all PE requirements are met. The eligibility begins on date of signed application which will also be the date the PE Entity makes the PE determination. To be eligible for PE-NB, the applicant must:
1. Be a newborn who is not yet 4 months old.
  2. Be a citizen or, as defined in federal law, an eligible immigrant.
  3. Live in a family with adjusted gross income, as reported to the PE Entity, which is above 185% FPL and at or below 250% FPL.
  4. Work (through a parent or legal guardian) with the PE Entity to submit a complete, signed CoverKids application.
  5. Not have had PE-NB within the last 18 months.
  6. Not be currently enrolled in TennCare or CoverKids.
  7. Not be currently enrolled in comprehensive health insurance coverage.
  8. Not have been enrolled in comprehensive health insurance coverage that was voluntarily terminated at any time within the three months prior to the visit with the PE Entity.
  9. Not have access to state administered health insurance by means of a family member's employment with a state or local government agency.
- (c) Presumptive Eligibility For Children (PE-C) Transitioning from TennCare allows certain children whose TennCare coverage is ending to have immediate CoverKids coverage that begins on the day TennCare ends as long as all PE-C requirements are met. This effort is to ensure that there are no gaps in coverage. To be eligible for CoverKids PE-C, the child must:
1. Be under 19 years of age.

(Rule 0620-5-1-.02, continued)

2. Be a child for whom DHS has determined that TennCare coverage will end as a result of having too much income and not meeting spend down.
  3. Not be currently enrolled in CoverKids.
  4. Not be currently enrolled in comprehensive health insurance coverage.
  5. Have adjusted gross family income, as indicated on the DHS ACCENT system, at or below 250% FPL.
- (12) Changes in Family Status. If the family has applied for CoverKids and coverage was denied, applicants may reapply for CoverKids any time a change occurs that may make them eligible. This could include a change in family size, pregnancy, loss of a job, or change in family income. (A change in the child's health status does not make a child eligible for CoverKids.) If a family has a change in status that makes the children newly eligible for CoverKids, the family should reapply as soon as possible.
- (13) Annual Redetermination of Eligibility.
- (a) Eligibility determinations will be done annually. The AC will mail a CoverKids redetermination form to families within 60 calendar days of the beneficiary's last day of continuous eligibility. The family will complete the application, note changes, attach documentation, sign it and return it to AC. The AC will make an eligibility determination for each applicant on the redetermination form.
  - (b) For beneficiaries above 250% of the FPL who continue to be otherwise eligible, CoverKids eligibility will continue as long as the family continues to pay premiums for the next year.
- (14) Pregnant women with income above 250% of the Federal poverty level will only be eligible for CoverKids enrollment if they are presently enrolled in the CoverTN program or presently enrolled in the CoverKids program.
- (15) Enrollment Caps.
- (a) Enrollment of children with income (as previously defined in this regulation) less than 250% of the Federal Poverty Limit is dependent on federal funding under the SCHIP program authorized in Title XXI of the Social Security Act, and may be limited by
  - (b) Federal laws and regulations governing the SCHIP program and the funding allocated to the state of Tennessee.
  - (c) Enrollment of children with income greater than the 250% of the Federal Poverty Limit may be subject to enrollment caps at the discretion of CoverKids management.
  - (d) Enrollment of pregnant women over 250% of the Federal Poverty Limit is limited to pregnant women already enrolled and in good standing with the CoverKids program and women already enrolled in CoverTN.

**Authority:** T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.

**0620-5-1-.03 COST SHARING—PREMIUMS AND CO-PAYS.**

(Rule 0620-5-1-.03, continued)

(1) Premiums.

- (a) CoverKids enrollees in families with income equal to or less than 250% of the Federal Poverty Limit will not be assessed premiums.
- (b) CoverKids enrollees in families with income greater than 250% of the Federal Poverty Limit will be assessed a monthly full premium for each beneficiary. The enrollee family is responsible for payment of the premium each month.
- (c) The premium will be determined by the State's insurance plan administrator based on its determination of historical costs and estimates of future costs over the life of the contract. This determination will be reviewed by CoverKids and will be posted on the website of the insurance plan administration. The website address and cost information will be distributed to the public by CoverKids.
- (d) Payment of the first month's premium will be required for services to begin.
- (e) Pregnant women with income greater than 250% of the Federal Poverty level shall pay premiums in advance for maternity related services only if she is presently enrolled in CoverKids program.

(2) Failure to Pay Premiums.

- (a) If the enrollee is delinquent in paying premiums and fails to pay the appropriate premiums within 31 days of the due date of the premium, the enrollee will be considered delinquent and may be subject to disenrollment from CoverKids.
- (b) When an enrollee is delinquent in paying a premium, the health plan will notify the family, in writing, of:
  - 1. The amount due.
  - 2. The date the past due premium must be paid.
  - 3. The disenrollment from the health plan if the past due premium is not paid.
  - 4. The date coverage will end.
  - 5. The need to report any change in circumstances (for example: loss of income, additional family members, or requirement to pay child support for a child not living with the family) which may result in a new determination of eligibility.
  - 6. The right to request a health plan review and a Department Review and the procedures to follow in requesting a review.
- (c) A delinquency notice will be issued on the day that the payment is due if payment has not been received. A termination notice will issue if the payment is not received within 31 days of the due date.
- (d) All reviews will be conducted according to the procedures in rule 0620-5-1-.05.
- (e) Once disenrolled from CoverKids for failure to pay required premiums, applicants will not be eligible for CoverKids coverage until payment for unpaid amounts is made and for six (6) months after the disenrollment for nonpayment of premiums. In these cases, a new CoverKids application must be submitted. Applications received within one month of the month that follows the six month period will be accepted. Coverage will

(Rule 0620-5-1-.03, continued)

not begin before the first month's premium and all previously unpaid premium amounts have been paid.

## (3) Co-Pays.

- (a) CoverKids will assess co-pays for certain covered services as detailed in the chart attached as follows:

BENEFIT	FAMILY INCOME BETWEEN 150-250% FPL	FAMILY INCOME AT OR BELOW 150% FPL
Annual Deductible	None	None
Preexisting Condition Requirement	None	None
Physician Office Visit	\$15 copay PCP; \$20 copay specialist	\$5 copay PCP or specialist
Hospital Care	\$100 per admission (waived if readmitted within 48 hours for same episode)	\$5 per admission (waived if readmitted within 48 hours for same episode)
Prescription Drug Coinsurance/Copay	\$5 generic; \$20 preferred brand; \$40 non-preferred brand	\$1 generic; \$3 preferred brand; \$5 non-preferred brand
Maternity	\$15 copay OB, first visit only; \$20 copay specialist; \$100 hospital admission	\$5 copay OB or specialist, first visit only; \$5 hospital admission
Routine Health Assessment and Immunizations – Child	No copays for services rendered under American Academy of Pediatrics guidelines	No copays for services rendered under American Academy of Pediatrics guidelines
Emergency Room	\$50 copay per use (waived if admitted)	\$5 copay per use in case of an emergency (waived if admitted); \$10 copay per use for non-emergency
Chiropractic Care	\$15 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur	\$5 copay; Maintenance visits not covered when no additional progress is apparent or

(Rule 0620-5-1-.03, continued)

		expected to occur
Ambulance Service – Air & Ground	No copay 100% of reasonable charges when deemed medically necessary by claims administrator	No copay 100% of reasonable charges when deemed medically necessary by claims administrator
Lab and X-ray	No copay 100% benefit	No copay 100% benefit
Physical, Speech & Occupational Therapy	\$15 copay per visit; Limited to 52 visits per year per condition	\$5 copay per visit; Limited to 52 visits per year per condition
Mental Health Inpatient (preauthorization required)	\$100 copay per admission; Limited to 30 days per year	\$5 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient (preauthorization required)	\$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay	\$5 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health/Substance Abuse Outpatient (preauthorization required)	\$20 copay per session; Limited to 52 sessions mental health and substance abuse combined	\$5 copay per session; Limited to 52 sessions mental health and substance abuse combined
Annual Out-of-Pocket Maximums	5% of family income	5% of family income

No co-payments will be charged for well-child visits, immunizations, or lab and x-ray services. There is also no co-payment for ambulance services when deemed medically necessary by the health plan. For children in families with income at or below 150 percent of the Federal Poverty Limit, co-payments will not exceed \$5.00, except the co-payment for non-emergency use of the emergency room will be \$10.

- (b) For enrollees with family income equal to or under 250% of the Federal Poverty Limit, the aggregate cost sharing for a family shall not exceed 5% of the family's annual income.
- (c) As required by Federal law, American Indian and Alaska Native children as defined by the Indian Health Care Improvement Act of 1976 will be exempt from all cost sharing.
- (d) A family that does not pay a required co-payment remains enrolled in the program. An individual provider may at his or her discretion refuse service for non-payment of a co-payment unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay co-payments.

(Rule 0620-5-1-.03, continued)

**Authority:** T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.

**0620-5-1-.04 DISENROLLMENT.**

- (1) Grounds for Disenrollment from CoverKids. Once enrolled in CoverKids, children are financially eligible for 12 months, except in the following situations, which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period.
  - (a) An enrollee, through an authorized family member, requests disenrollment.
  - (b) Nonpayment of premiums, as described more fully in regulation 0620-5-1-.03.
  - (c) Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.
  - (d) A CoverKids enrollee moves from the state.
  - (e) Death of a CoverKids enrollee.
  - (f) A CoverKids enrollee is enrolled in TennCare.
  - (g) A CoverKids enrollee meets a TennCare Medicaid spend-down.
  - (h) A CoverKids enrollee turns age 19.
  - (i) A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth post-partum day occurs.
  - (j) A CoverKids enrollee gains access to state-sponsored health insurance through a family member's employment with a state or local education agency that has state sponsored health insurance or contributed to state sponsored health insurance as defined in 42 C.F.R. 457.301.
  - (k) A CoverKids enrollee is enrolled into individual, group or employer-based coverage.
  - (l) A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentations by an enrollee, parent, guardian, or representative.
- (2) Procedures.
  - (a) Disenrollments shall be conducted under the procedures set forth in rule 0620-5-1-.05 of these rules.

**Authority:** T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.

**0620-5-1-.05 ADMINISTRATIVE REVIEW OF COVERKIDS DECISIONS.**

- (1) Eligibility and Enrollment Matters. The parent of an enrollee or applicant may obtain review of a denial of eligibility, suspension or termination of enrollment (including termination for failure to pay premiums or cost sharing), or a situation in which eligibility decisions have not been made in a timely manner, through the following procedures.

(Rule 0620-5-1-.05, continued)

(a) Informal Review.

1. A parent will be notified of a denial of eligibility or suspension or termination of enrollment in writing, and such notice will contain the reason for the denial, the procedures for seeking review of this decision, and the anticipated time by which review will be completed. Parents may also request a review for situations in which eligibility determination have not been made in a timely manner. Parents will be notified that termination or suspension of enrollment will not be effective until the completion of the review process provided in these rules.
2. Parents may request review by sending a written request to the Administrative Contractor (AC) or calling the eligibility and enrollment AC's toll-free number. This request for review must be received by the AC within 30 days of issuance of written notice of the action for which review is requested or, if notice is not provided, 30 days from the time the applicant becomes aware of the action.. They may report additional information or clarify information on the applicant's account. The AC will document the call and any additional information/clarification provided. AC eligibility staff will review the matter.
3. If the AC's review does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. The notification letter will inform the parent that they may submit a formal request in writing to the Division of Insurance Administration, to be reviewed by the state-level CoverKids Eligibility Appeals Committee.

(b) Formal Review.

1. The parent may request a formal review of the informal review decision with a parent may request a formal review of the informal review decision with a written request to the Division of Insurance Administration. This request must be received by the Division within 30 days of issuance of the informal review decision. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that a decision should be issued within one calendar month of receipt of the acknowledgment letter.
2. The Eligibility Appeals Committee, composed of five Division of Insurance Administration staff members, will review eligibility and enrollment matters. The members of this committee shall not have been directly involved in the matter under review. If the Committee disagrees with the decision of the AC, the child will be enrolled in CoverKids. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in CoverKids, the enrollment will become effective retroactive to the first day of the month following the initial eligibility determination.
3. Parents may represent themselves or have a representative of their choosing in connection with formal reviews. Parents may review information relevant to the review of the decision in a timely manner and may submit supplemental information during the review process. Enrollees will remain enrolled pending completion of the review in the case of suspension or termination of enrollment.
4. The Committee is not required to conduct in-person hearings or to conduct a contested case under the requirements of the Uniform Administrative Procedures Act.

(Rule 0620-5-1-.05, continued)

5. If the Committee agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. The decision of the Eligibility Appeals Committee will be the final administrative recourse available.
- (c) Deadlines for Review.
1. Expedited review will be provided if an applicant provides a statement from a medical professional that she or he has a medical situation that is life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. Expedited review should be completed within 10 days of receipt of the request.
  2. All enrollment or eligibility matters not subject to expedited review shall be determined within a reasonable time.
- (2) Health Services Matters. A parent of a CoverKids enrollee may request review of a Cover Kids action to delay, deny, reduce, suspend, or terminate health services, or a failure to approve, furnish, or provide payment for health services in a timely manner, according to the following provisions.
- (a) Notice. Any decision denying, or delaying a requested health service, reducing, suspending, or terminating an existing health service, or failure to approve, furnish, or provide payment for health services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health services may continue pending review unless there is question that the existing health services are harmful.
  - (b) Contractor Review. Parents commence the review process by submitting a written request to the Plan Administrator (PA) within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action not to exceed six (6) months from when the action occurred. The PA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. This determination should be made in legible writing with an original signature.
  - (c) State Informal Review. After the PA's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to the State Division of Insurance Administration which must be received within 8 days of the Administrator's decision. The Appeals Coordinator within the Division will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the state's independent medical consultant. A written decision of the Appeals Coordinator should be issued within 20 days of receipt of the request for further review.
  - (d) State Review Committee. If the informal review does not grant the relief requested by the parent, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of Insurance Administration staff and at least one licensed medical professional, selected

(Rule 0620-5-1-.05, continued)

by the Commissioner or his designee. The members of the Committee will not have been directly involved in the matter under review. The parent will be given the opportunity to review the file, be represented by a representative of the parent's choice, and provide supplemental information. The Committee may allow the parent to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.

- (e) Time for Reviews. Review of all non-expedited health services appeals will be completed within 90 days of receipt of the initial request for review by the PA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each the PA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) that the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning.
- (3) Scope of Review. CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

**Authority:** T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110. **Administrative History:** Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.